

# **AccuReview**

An Independent Review Organization

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## **Notice of Independent Review Decision**

**[Date notice sent to all parties]: August 27, 2012**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Work Hardening 5xWk x 2Wks 80 Hours (R inguinal hernia) 97545 97546

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 years of experience.

### **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

03-15-12: Status Report: Initial Evaluation:

Texas Workers' Compensation Work Status Report

03-23-12: Texas Workers' Compensation Work Status Report

04-03-12: Office visit note

04-03-12: Texas Workers' Compensation Work Status Report 05-24-12:

Specialist Referral Slip

06-11-12: Initial Behavioral Medicine Consultation

06-11-12: Multidisciplinary Work Hardening Plan & Goals of Treatment

06-19-12: Functional Capacity Evaluation Summary

06-27-12: History & Physical

06-29-12: Work Hardening Pre-Authorization Request

07-05-12: UR performed

07-12-12: Reconsideration: Work Hardening Program Pre-Authorization Request  
07-19-12: UR performed

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained a work related injury to his right abdomen, groin, and right testicle while performing his customary duties. He was helping a co-worker lift approximately 200 pounds when the co-worker lost control of his end causing the claimant to take the extra weight. He reported the injury to his supervisor and sought medical treatment the same day.

03-15-12: Status Report: Initial Evaluation Description of Injury: Today, lifting 200+ pounds with another person and felt a sharp pain in lower right side of abdomen. Claimant states a burning sensation in lower right side of abdomen. Pain scale: 6-7/10 with radiation into right side. Claimant stated a prior operation same side for an inguinal hernia 10 years ago. Physical Exam: ABD: No pulsative masses. Other reported findings: Aggravated discomfort with bending or twisting just above right medial inguinal ligament. Hernial critics and tests are negative. However, pain with mild-moderate palpation just above right inguinal ligament. No rebound tenderness. No appreciation of any abdominal wall defect. Flat and upright radiographs negative for any obstructive patterns. Diagnosis: Right Inguinal Hernia. Recommendations: 1. No physical therapy at this time. 2. Medication: Naprosyn 500mg #14. 3. Surgery referral. Claimant warned regarding crescendo discomfort. 4. Modified duties. 5. Recheck in 24 hours because of location of pain. 6. Referral to the Surgery.

04-03-12: Office note. Physical Examination: Right inguinal region: Swelling noted at the medial end of previous surgical scar, present when claimant stands up. Impulse on coughing present. Claimant advised for surgical repair of recurrent right inguinal hernia with mesh.

06-11-12: Initial Behavioral Medicine Consultation. Reason for referral: Determining the claimant's suitability for a comprehensive, multidisciplinary RTW program. Claimant stated that he underwent hernia surgery repair on 4/11/12 and was returned to work 3 weeks later. Claimant presented with pain 4/10 with average daily pain as 5-6/10 with intermittent elevations of 7/10, since his injury. He notes having aching, numbness, with pins and needles in his right lower abdomen. When asked to quantify the level of interference his pain has on his recreational, social, and familial activities, he rates these all as 5/10; for pain interference with normal activities as, 5/10; and change in ability to work, 5/10. He is currently working with a 15 pound weight restriction. Lifestyle changes related to the injury: The claimant reports a difficulty with acts of living to include: self-grooming, caring for children, exercise/playing sports, driving 30 minutes, sitting 20 minutes, standing 20 minutes, walking 30 minutes, bending, squatting, lifting/carrying 15 pounds, climbing stairs, and sexual activity. Claimant also noted changes in self-perception to include: loss of confidence, feeling lack of control in his life, and feeling disappointed/angry with him-self. He endorses initial

and sleep maintenance insomnia (difficulty falling asleep and 3-4 awakenings per night, due to pain. Claimant reported his overall functioning prior to injury as 95%, and his current level of overall functioning as 50%. Multiaxial Diagnosis: Axis I: 307.89 Pain Disorder associated with both psychological factors and a general medical condition; acute; Axis II: V71.09, no diagnosis; Axis III: Injury to right abdomen, groin, and right testicle; Axis IV: Primary Support Group and Housing Problems; Axis V: GAF: current 60; Estimated pre-injury: 85+. Claimant has since injury had passive and physical therapy, yet continues to struggle with moderate to severe pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. Given the information gathered in this intake, the patient would be an excellent candidate for the Work Hardening Program and his psychological problems may be effectively addressed in didactic group therapy services offered in this program.

06-19-12: Functional Capacity Evaluation Summary . Claimant presented with complaints of constant right lower quadrant pain that is described as a throbbing, tingling and burning sensation. Pain is said to increase with prolonged sitting and prolonged standing. Lying down is said to aid with pain reduction. Pain is localized in the right lower quadrant of the abdomen. Claimant's current job requirement is a PDL of Heavy. Assessment: Claimant demonstrates moderate to severe signs of decreased functional ability, as noted in the evaluation, due to injuries to the right lower abdominal quadrant sustained secondary to a work related injury. Based on the history and exam findings, it is of the opinion that the claimant has reached a current PDL of Medium. Suggested Restrictions: 1. Limit lifting from the floor to the waist to 50 lbs. 2. Limit lifting from the waist to the shoulder level to 40 lbs. 3. Limit lifting from the waist to the overhead level of 40 lbs. 4. Limit waist level up to 20 meter carry to 40 lbs. 5. 0-2 hours of lifting, stair climbing, and/or ladder climbing. 6. 2-4 hours of intermittent standing, walking, bending, and/or squatting. 7. 4-6 hours of intermittent reaching up, reaching out, and/or sitting. 8. Claimant will need to be able to take frequent breaks to change position to aid pain reduction.

06-27-12: History & Physical. Work status: Limited duty. Clinical Findings: Pain on palpation at RLQ, right inguinal region. Strength decreased: trunk flexion/extension. ADL limitations: lifting, flank. Diagnosis: 1. Hernia, 2. S/P Hernia Repair 4/11/12. Titration Plan: Week 1: Tramadol PRN, Week 2: Tramadol PRN, Week 3: D/C.

06-29-12: Work Hardening Program Pre-authorization Request by Injury 1 of Dallas/Ft. Worth. The claimant has shown modest improvement with outpatient physical therapy modalities and we are now recommending progression to a Work Hardening Program for progress to continue to be achieved. It is clear from the functional capacity evaluation that the current level of functioning due to injury interferes with his ability to safely carry out specific tasks required at his workplace without risk of further injury and/or aggravation of the condition. We expect to regain full-duty status upon completion of the program.

07-05-12: UR. Reason for denial: The claimant sustained an injury due to heavy lifting, and underwent successful herniorrhaphy. He reportedly has shown modest improvement with physical therapy; however, no physical therapy progress notes were submitted for review with documentation of the total number of visits completed, modalities used, and response to treatment with evidence of improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Psychological evaluation showed moderate levels of depression (BDI-II=25) and anxiety (BAI=19). Per FCE the claimant currently is capable of Medium PDL, with job demand of Heavy PDL. There is no specific, defined return to work goal, and it is unclear if the claimant has a job to return to. Based on the clinical information provided, medical necessity is not established.

07-12-12: Reconsideration: Work Hardening Program Pre-authorization Request. Response to Denial: Claimant has been working with restrictions since the date of injury. He was off work for about 3 weeks after his surgery. The claimant has not completed any physical therapy and would like to return to work with no restrictions.

07-19-12: UR performed. Reason for denial: This is an appeal for 80 hours of work hardening, five times a week for two weeks, for a patient who is status post right inguinal herniorrhaphy on 4/16/12. The request was previously denied due to lack of physical therapy progress notes documenting the total number of visits completed, modalities used and response to treatment with evidence of improvement followed by plateau. There was also no specific, defined return to work goal, and it was unclear if the patient has a job to return to. Updated documentation included a report dated 7/12/12 clarifying that the patient has not had any physical therapy treatments prior to this request and is currently working with restrictions. The proposed treatment will enable the patient to work as a welder without restrictions. The report cites the ODG does not recommend physical therapy for hernia type injuries. Review of the referenced guidelines indicates that this recommendation is within the context of comparing outcomes of rehabilitative modalities to surgical interventions. The patient has already undergone hernia repair and work hardening recommendations require an adequate trial of active physical rehabilitation prior to progression to the aforementioned program. Additionally, the patient is working with restrictions at this time and there is no indication that any current deficits cannot be addressed by less intensive interventions. Hence, the medical necessity of this request has not been sustained, and the previous non-certification is upheld. Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced above, this appeal for work hardening of five times a week for two weeks, 80 hours unit trial (recurrent right inguinal hernia) is not certified.

## ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Denial of work hardening is overturned/disagreed with. ODG Hernia Chapter does not recommend Physical Therapy. Therefore, any request for basic PT could be denied based upon this recommendation. So, therefore the criteria of lower levels of rehabilitation prior to work hardening are mute. Furthermore, ODG Hernia chapter does not address work hardening but does address and recommend work restrictions. FCE reveals obvious deconditioned state of dysfunction/decondition and inability to meet heavy job demands now several months post injury. And a Behavioral Assessment reveals significant psychological barriers to recovery. Therefore, per ODG Pain chapter, work hardening is now the most appropriate level of rehabilitation and medically necessary to meet full duties/productivity/function. Based on the review of the medical records provided and documentation the request for Work Hardening 5xWk x 2Wks 80 Hours (R inguinal hernia) 97545 97546 is overturned and approved.

Per ODG:

Work conditioning, work hardening	<p><b>Criteria for admission to a Work Hardening (WH) Program:</b></p> <p>(1) <i>Prescription:</i> The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(2) <i>Screening Documentation:</i> Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.</p> <p>(3) <i>Job demands:</i> A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).</p> <p>(4) <i>Functional capacity evaluations (FCEs):</i> A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.</p> <p>(5) <i>Previous PT:</i> There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.</p> <p>(6) <i>Rule out surgery:</i> The patient is not a candidate for whom surgery, injections, or other</p>
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	<p>treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).</p> <p>(7) <i>Healing</i>: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.</p> <p>(8) <i>Other contraindications</i>: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.</p> <p>(9) <i>RTW plan</i>: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.</p> <p>(10) <i>Drug problems</i>: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.</p> <p>(11) <i>Program documentation</i>: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.</p> <p>(12) <i>Further mental health evaluation</i>: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.</p> <p>(13) <i>Supervision</i>: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.</p> <p>(14) <i>Trial</i>: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.</p> <p>(15) <i>Concurrently working</i>: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.</p> <p>(16) <i>Conferences</i>: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.</p> <p>(17) <i>Voc rehab</i>: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.</p> <p>(18) <i>Post-injury cap</i>: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see <a href="#">Chronic pain programs</a>).</p> <p>(19) <i>Program timelines</i>: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether</p>
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	<p>treatment of greater intensity is required.</p> <p>(20) <i>Discharge documentation:</i> At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.</p> <p>(21) <i>Repetition:</i> Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.</p> <p><b><i>ODG Work Conditioning (WC) Physical Therapy Guidelines</i></b></p> <p>WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also <a href="#">Physical therapy</a> for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.</p> <p><i>Timelines:</i> 10 visits over 4 weeks, equivalent to up to 30 hours.</p>
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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)